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Office of Administrative Law Judges
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Issue Date: 31 July 2007

In the Matter of

N.M.S.,
Claimant

v.

VIRGINIA IRON COAL & COKE CO.,

Employer

and

COASTAL COAL COMPANY, LLC,

Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case No. 2006-BLA-05492

Appearances: Andrew Delph, Esq.
Wolfe, Williams and Rutherford
For the Claimant

Denise M. Davidson, Esq.
Barrett, Haynes, May, Carter and Davidson
For the Employer

Before: William S. Colwell
Associate Chief Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a

chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on August 22, 2006, in Kingsport, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Administrative Law Judge Exhibits ("ALJX") 1-6; Director's Exhibits ("DX") 1-40, and Employer's Exhibits ("EX") 1-4 were admitted into evidence. Transcript ("Tr.") at 7-15. However, after reviewing the merits of Claimant's objection to part of Employer's Exhibit 1, a portion of EX 1 will be excluded, specifically Dr. Wiot's three reviews of CT scans dated November 11, 2002; May 17, 2002; and December 28, 2001.[1] Thus, Employer's Exhibit 1 has been admitted only as to the two chest x-ray re-readings by Dr. Wiot of films dated January 26, 2006 and May 12, 2005. The record was held open after the hearing to allow the parties to submit additional argument. The Employer submitted a closing argument, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his claim for benefits on February 1, 2005. DX 2. On November 17, 2005, the District Director issued a Proposed Decision and Order Awarding Benefits after finding the existence of pneumoconiosis that had arisen out of the Claimant's coal mine employment, and total disability due to this disease. The Employer timely appealed that determination, and the case was referred to this office on March 15, 2006. DX 32; DX 38.

APPLICABLE STANDARDS

Since this claim was filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose at least in part out of his coal mine employment, that he is totally disabled, and that the pneumoconiosis is a substantially

[1] At the hearing, Claimant's attorney objected to the admission of this portion of EX 1 because it was evidence in "rebuttal" of treatment records. Tr, 12. This argument has merit, in that the Board has held, albeit in an unpublished decision, that the provisions of § 725.414(a)(4) do not allow for the rebuttal of treatment records. *Henley v. Cowin & Co*, BRB No. 05-0788 BLA (May 30, 2006). The CT scan readings by Dr. Wiot were in response to the initial readings of these same scans by Dr. Robinette, contained in DX 11, and listed on the Employer's Evidence Summary Form under the category "Hospitalization and treatment notes." ALJX 4.

contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004).

ISSUES

The following are the remaining contested issues:

1. The length of the Claimant's coal mine employment;

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

5. Whether his disability is due to pneumoconiosis.

The Employer also reserved its right to challenge the statute and regulations. These issues are beyond the authority of the administrative law judge and are preserved for appeal purposes only.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background

Claimant was born on March 21, 1962. DX 2; DX 17. He was married to B.M. on May 27, 1992, and they are still married, living in Virginia. DX 2; DX 17; Tr. 17. They have no dependents at this time. DX 17; Tr. 18. The Claimant graduated from the twelfth grade and has not had any training, vocational or otherwise, to prepare him for another skill or vocation. The Claimant testified that he smoked cigarettes for about 22 years at an average rate of about 1½ packs per day. Tr. 21. He also testified that Dr. Robinette's report of his smoking five packs per day was incorrect. Tr. 24. However, Claimant stated in a previous deposition that he smoked for about 26 years at the rate of 1½ to 2 packs per day. DX 17. The Claimant reported to other physicians a smoking history of 27 or 28 pack years. EX 2; DX 12.

The Claimant last worked in coal mine employment in January of 1993, when he was "laid off" from Virginia Iron Coal. DX 2; DX 17; Tr. 22. His last job in the mines was a "maintenance helper," with the responsibilities of shoveling beltlines, cleaning out tunnels, cleaning the preparation plant, sand blasting, greasing the beltlines and doing whatever job needed to be done. DX 4; DX 17; Tr. 23. This work involved sitting for about ½ hour per day, standing for about 7.5 hours a day, lifting 50 pounds once a day and carrying 50 pounds about 25 yards once a day. DX 4. For six years prior to being hired as a maintenance helper, Claimant worked for Virginia Iron Coal as a security guard on the mine site. DX 3; DX 4; DX 19; Tr. 17-19. In this position, Claimant would

patrol the site and the stockpiles and prevent coal mining equipment and coal from being stolen. Tr. 17-18. Claimant stated that he would drive around the mine site in a vehicle provided by the Employer, mostly during production shifts, and essentially, guard the premises from trespassers. In this job, he did not operate any mining equipment, but would sometimes sit near the coal pits. After he was laid off from Virginia Coal in 1993, the Claimant worked as a state prison correctional officer until 2003. DX 17; Tr. 23. His last coal mine employment was in Virginia. Tr. 25. Therefore this claim is governed by the law of the 4th Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Claimant reported that he has not worked anywhere since leaving mining in April of 2004. DX 2; DX 19; Tr. 19; Tr. 21. The Claimant said that he injured his back on the job and could not return to work after that time. He has had neck surgery as a result of his injury.

Claimant testified that he has had breathing problems "for some time" and is now on oxygen 24 hours a day, 7 days a week. Tr. 18; Tr. 24-25. He cannot walk through his house without becoming short of breath. Tr. 19. He has seen Dr. Nida over the past 7 years for his breathing problem, and this doctor prescribed his oxygen, along with an inhaler and nebulizers for his condition. DX 17. The Claimant stated that Dr. Nida diagnosed chronic obstructive pulmonary disease in 1999. DX 17. The Claimant said he has been hospitalized for his respiratory condition about 6 or 7 times. He is also diabetic, has sleep apnea, suffers from muscle spasms, and has had surgery on his vocal chords. DX 17. Drs. Wade and Rybal treated him for his throat problem. The Claimant has also seen Drs. Barron, Blackwell, Pellegrini and McSherry for his pulmonary problem. Dr. Garrett removed his gall bladder. Dr. Robinette found nodules on the Claimant's left lung and has been following up with the Claimant for about a year. His current treating medical professionals include Drs. Nida and Robinette, and a nurse practitioner, Teresa Gardner.

Length of Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant bears the burden of proof in establishing the length of his coal mine work. *See Shelesky v. Director, OWCP*, 7 BLR 1-34, 1-36 (1984); *Rennie v. U.S. Steel Corp.*, 1 BLR 1-859, 1-862 (1978). On his application for benefits, Claimant alleged 11 years of coal mine employment. The District Director found 10.94 years, which includes all of his time as an employee of Virginia Iron Coal. Claimant testified that he only performed coal mine work for this employer and has not performed coal mine work at any other time in his employment history. The Employer challenges the Director's finding of 10.94 years and raises the issue of whether the Claimant was a "miner" as defined under the regulations when he worked a security guard.

The regulations at §725.202(a)(19) provide:

> Miner or coal miner means any individual who works or has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. The term also includes an individual who works or has worked in coal mine construction or transportation in or around a coal mine, to the extent such individual was exposed to coal mine dust as a result of such employment (see §725.202(a).)

20 C.F.R. §725.202(a)(19)(2001). In addition, the regulations at §725.202(a) provide a rebuttable presumption that certain individuals are miners:

> Miner defined. A 'miner' for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner. This presumption may be rebutted by proof that:
>
> (1) The person was not engaged in the extraction, preparation, or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or
>
> (2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

20 C.F.R. §725.202(a)(2001).

The Board has established a three prong test to determine whether a worker is a "miner" within the meaning of the Act. *Whisman v. Director, OWCP*, 8 B.L.R. 1-96 (1985). The worker must prove that: (1) the coal was still in the course of being processed and was not yet a finished product in the stream of commerce (status); (2) the worker performed a function integral to the coal production process, *i.e.*, extraction or preparation, and not one merely ancillary to the delivery and commercial use of processed coal (function); and (3) that the work was performed, occurred in or around a coal mine or coal preparation facility (situs). The Fourth Circuit, in which this claim arises, has employed a two-prong, function-situs test in determining whether a worker qualifies as a miner under the Act. *Collins v. Director, OWCP*, 795 F.2d 368 (4th Cir. 1986). I note that the Employer has submitted, post-hearing, a copy of a Sixth Circuit case in which a security guard employed at a mine site was not considered to be a "miner" under the Act for purposes of qualifying employment. *Falcon Coal v. Corbett Clemons, et al.,* 873 F.2d 916 (6th Cir. 1989). This case is persuasive in that the Sixth Circuit applies a two-prong, function-situs test, as well. The Claimant in *Falcon* patrolled the grounds in a vehicle, just as the Claimant in the case at bar. The Court

reasoned that, although Claimant's duties may have been "convenient or helpful" to the Employer's mine operation, his job was not "necessary to procure coal." The Court also noted that exposure to coal dust has no relevance in determining whether an individual is a miner (citing *Nucci v. Director, OWCP,* BRB No. 82-922 BLA (Mar. 26, 1984) (unpublished)). The Sixth Circuit Court relied, in part, on an unpublished case from the Fourth Circuit holding that a night-watchman who worked as on-site security near the tipple during mine operations was not a "miner" under the statutory definition. *See Director, OWCP v. West Virginia Workers' Compensation Coal-Workers' Pneumoconiosis Fund; Henry J. Lambert*, No. 86-1222, 842 F.2d 1290 (4th Cir. Mar. 8, 1988).

Claimant has certainly satisfied the "situs" prong of the "miner" test. However, as in *Falcon* and *Lambert*, Claimant's duties were not "integral" to the coal production process, *i.e.*, the extraction or preparation of coal. Applying the situs-function test and relying on the relevant Circuit cases outlined, above, I find that Claimant was not a miner during the first six years he worked for the Employer, as a security guard. The parties do not dispute that Claimant qualified as a "miner" under the Act when he worked as a "maintenance helper" at Virginia Iron Coal from August of 1989 until he stopped working in the mines in January of 1993. Further, Claimant testified that he has performed mining work only while working for Virginia Iron Coal. Therefore, I find that the record establishes a total of 3.5 years that Claimant worked in qualifying coal mine employment.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 (2004) and Appendix A of Part 718. The following table summarizes the x-ray findings submitted by the parties in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute

of Occupational Safety and Health (NIOSH).[2] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 12(a) 5/12/05 5/17/05	Rasmussen B	ILO Classification 0/1 Quality 2	Negative (OWCP evaluation)
DX 13 5/12/05 6/6/05	Barrett B, BCR	Quality reading only Quality 1	Quality Reading only
EX 1 5/12/05 8/29/05	Wiot B, BCR	ILO Classification 0/0 Quality 3	Negative
EX 1 1/26/06 2/9/06	Jarboe B	ILO Classification 0/0 Quality 2	Negative
EX 1 1/26/06 3/30/06	Wiot B, BCR	ILO Classification 0/0 Quality 2	Negative

Pulmonary Function Tests

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. If there is greater resistance to the flow of air, there is more severe lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 (2004) and Appendix B. The following chart summarizes the results of the PFTs produced and available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary test, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV

[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Test Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 12(a) 5/12/05 Rasmussen (OWCP evaluation)	43 67"[3]	2.55/ 2.67	3.61/ 3.56	72%/ 75%	---	No	Minimal irreversible obstructive impairment
EX 2 1/26/06 Jarboe	43 68"	2.18 2.43	3.22 3.35	68% 73%	52 57	No	Mild restrictive and mild obstructive defect

Blood Gas Studies

Arterial blood gas (ABG) studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 CFR § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically not advisable. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 12(a)	5/12/05	Rasmussen	36 36	68 57	No Yes	Minimal resting hypoxemia
DX 12	Dr. Michos (pulmonary specialist) validated study of 5/12/05					
EX 2	1/26/06	Jarboe	38.4	88.8	No	

[3] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner, I have taken the average (67.5") in determining whether the studies qualify to show disability under the regulations.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis is a substantially contributing cause of the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 CFR § 718.201. See 20 CFR § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004).

Where total disability can not be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). Quality standards for reports of physical examinations are found at 20 CFR § 718.104 (2004). The record contains the following medical opinions relating to this claim.

Dr. D.L. Rasmussen (Examination on behalf of OWCP)

On May 12, 2005, Dr. Rasmussen examined the Claimant on behalf of the Department of Labor. DX 12(a). Dr. Rasmussen is board certified in internal medicine and Forensic Medicine and is a B-reader. He took social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, pulmonary function testing and EKG. This doctor noted a coal mining history of 11 years between 1982 and 1993, and a smoking history of about one pack of cigarettes per day for about 28 years. Based on this information, Dr. Rasmussen diagnosed chronic obstructive pulmonary disease (COPD) and emphysema, based on his chronic productive cough, airflow obstruction and reduced SBDLCO. He attributed the miner's COPD and emphysema to a combination of cigarette smoking and coal mine dust exposure. This doctor found the EKG normal. Concerning impairment, he found that Claimant "did not retain the pulmonary capacity to perform his last regular coal mine job." He found several causes for Claimant's disabling disease:

> He did have an eleven-year history of at least minimal exposure to silicon dioxide and coal dust. He was also exposed to spray paints. In addition,

> he had a 28-pack year history of cigarette smoking. He reports having had a diagnosis of pulmonary hypertension, however, the details are not known. Also he has sleep apnea, which has been treated since 1996 with C-PAP and BI-PAP. (Sleep apnea can cause pulmonary hypertension as could COPD/emphysema). His physiologic findings, however, are not particularly suggestive of pulmonary hypertension. [Claimant] also has lifelong history of bronchial asthma. Bronchial asthma itself can lead to remodeling of airways with permanent airway obstruction. It is not usually felt to be associated with emphysema. Clearly his asthma could contribute to his airway obstruction.

Dr. Rasmussen concluded that Claimant had "insufficient radiographic changes to justify medical pneumoconiosis." However, this doctor believed that Claimant had legal pneumoconiosis based on eleven years of coal mine employment "which is sufficient to contribute to his chronic obstructive lung disease. He believed that Claimant's coal mine dust exposure contributes, "even if minimally," to Claimant's disabling lung disease.

Dr. Emory H. Robinette

Dr. Emory H. Robinette saw Claimant on several occasions in 2002 during follow-up visits for "underlying obstructive sleep apnea and multiple pulmonary nodules." DX 10. This physician found the nodules "stable" and noted that Claimant had a "mild obstructive lung disease," with some specific thickening of his upper airway. In his progress notes, Dr. Robinette described Claimant's past history of surgery on his throat and a smoking history of five packs of cigarettes per day for 22 years. In January of 2002, Dr. Robinette's impression was as follows: 1) obstructive lung disease with possible components of variable extrathoracic obstruction with a prior ENT surgery requiring debridement of coal cord polyps and scar tissue in the upper airway; 2) obstructive lung disease with a history of chronic cigarette consumption; 3) non-insulin dependent diabetes mellitus; 4) sleep apnea; and 5) obesity. In his progress notes for Claimant, Dr. Robinette never mentions the existence of pneumoconiosis or any other disease induced by Claimant's exposure to coal mine dust. All of the CT scans the doctor ordered in 2002 were for the purpose of following up on the pulmonary nodules he had observed. Dr. Robinette's readings of those scans did not specifically address whether he found evidence of pneumoconiosis upon review.

Dr. Thomas M. Jarboe

Dr. Thomas M. Jarboe, who is board-certified in pulmonary disease and a B-reader, examined Claimant on January 26, 2006, and reviewed all medical opinions and reports of record to the date, including the reports and tests generated by Drs. Rasmussen and Robinette. EX 2; EX 4. Dr. Jarboe noted a 10-year coal mining history with six of those years as a security guard, and a 27-pack year smoking history. This doctor ordered an X-ray, pulmonary function test, and blood gas test. He also considered the patient's medical and family history and symptoms. Upon review of this

information and tests results, Dr. Jarboe found no evidence of pneumoconiosis by x-ray. His diagnoses included: 1) Bronchial asthma; 2) obstructive sleep apnea; 3) significant obesity; 4) essential hypertension; 5) history of muscle spasms; and 6) history of pulmonary hypertension, although he found "no physical or laboratory findings which would confirm this diagnosis." Dr. Jarboe did not believe that the "physiological evidence in this case suggests a dust induced lung disease." He did find a "mild ventilatory impairment," but believed that this impairment was caused by bronchial asthma and cigarette smoking and was not due to coal worker's pneumoconiosis. This specialist believed Claimant retained the functional respiratory capacity to do his last coal mine job or one with similar physical demands. Further, Dr. Jarboe did not find the "pulmonary hypertension" that Claimant reported to the doctor. Specifically, Dr. Jarboe noted no evidence of "increased pressures" on the right side of his heart that would indicate hypertension and he stated that, even if Claimant suffered from this condition, it would not be related to his occupation as a coal miner.

Dr. Jarboe was deposed on May 18, 2006, concerning his exam and diagnoses. EX 3. At that time, Dr. Jarboe explained that Claimant had a comparatively "marginal" or "minimal" exposure to coal dust from a medical standpoint. This doctor repeated his understanding of the Claimant's medical, occupational and smoking histories, along with the patient's current medication. He concluded that if Claimant did have pulmonary hypertension, it could be due to COPD, and that his obesity would also be a contributor. Dr. Jarboe suggested that these combined conditions, particularly in light of Claimant's abdominal obesity, produced the reason for his need for continuous oxygen. However, Dr. Jarboe found no respiratory or pulmonary impairment that was caused, in whole or in part, by the inhalation of coal dust. This physician also believed that Claimant was still smoking cigarettes, based on the patient's elevated nicotine and carboxyhemoglobin levels found by this doctor's testing. Claimant's pulmonary function values exceeded the regulatory standard for establishing total disability, according to this doctor. Dr. Jarboe did not diagnose emphysema and he specifically disagreed with Rasmussen on that diagnosis. He found no medical or legal pneumoconiosis. He also believed that his results were much different than Dr. Rasmussen's because of Claimant's bronchial asthma, and because asthma is a reversible airway disease and can be characterized by very different ventilatory profusion ratios in the lung. As this doctor explained:

> That is, one day your asthma is good, or in good shape, and you might be ventilating all the areas of your lungs beautifully. On another day you might not be doing so well and the areas in your lung might not be getting proper air and therefore you're shunting. If you don't get ventilation to a certain part of your lung, blood goes by there and dumps into the other side of the heart and it's not oxygenated. So asthma is characterized by that kind of physiology…. Now, the other thing that would add to that is the fact that this man is so obese. If his asthma was causing closure of his basal or lung units, that's going to be aggravated by the fact that he's very overweight. So I think the most likely explanation, the primary explanation, is asthma that would cause this degree of change.

Dr. Jarboe believed the Claimant's asthma and history of smoking resulted in the drop in his blood gases, as well. He explained that if coal dust inhalation had caused his impairment, he would expect a permanent change rather than the varied blood gas values. Finally, Dr. Jarboe repeated his opinion that Claimant was not totally disabled from a pulmonary standpoint and could return to his regular coal mine work. The record shows that Dr. Jarboe was familiar with the exertional requirements of Claimant's last coal mine work.

DISCUSSION AND APPLICABLE LAW

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on evidence from a (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions (not applicable here) described in Sections 718.304, 718.305, or 718.306, or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In order to determine whether the evidence establishes the existence of pneumoconiosis, I must consider the chest x-rays and medical opinions – the two categories of evidence applicable in this case.

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Analysis of X-Ray Studies

As discussed immediately below, none of the available x-ray studies support a finding of pneumoconiosis. Thus, I conclude that the Claimant has not established the existence of pneumoconiosis by virtue of the x-ray evidence.

May 12, 2005 X-Ray Study

The evidence shows that this study is negative for pneumoconiosis. Dr. Rasmussen, during the OWCP examination, found this study to be negative for pneumoconiosis. He is a B reader and on the list of medical examiners for the Department of Labor. Dr. Barrett determined that this film was of the highest quality "1." Dr. Wiot, who is a B-reader and board-certified radiologist, also determined that this film was negative for pneumoconiosis. His experience in radiology is extensive and includes service as a professor emeritus of radiology for the University of Cincinnati, Chairman of the Department of Radiology, Chief of Radiology, and numerous leadership positions in prestigious radiology organizations. He has published extensively in his field, and has been a national leader in developing ILO classifications and standards. Based on these negative readings by highly-qualified readers, I find the study does not support a finding of pneumoconiosis.

January 26, 2006 X-Ray Study

Dr. Jarboe, who is a B reader, found this study to be negative for pneumoconiosis. Dr. Wiot also found this x-ray to be negative. There is no rebuttal to this reading. Thus, I find this study is negative for pneumoconiosis.

Analysis of Medical Opinions

Medical Opinion Guidance

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984). Moreover, the qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984).

Balancing Conflicting Medical Opinions

The Claimant has not met his burden of proof to show – by medical opinion evidence – that he has pneumoconiosis. After weighing all of the medical opinions of record, I resolve this conflict by according the greatest probative weight to the opinion of Dr. Jarboe because of his excellent credentials in the field of pulmonary disease and because his report is the most comprehensive, taking into account all evidence of record from the filing of Claimant's first application for benefits. *See Church v. Eastern Assoc. Coal Corp.*, 20 B.L.F. 1-8 (1996), *aff'd in relevant part on recon.*, 12 B.L.R. 1-51 (1997), *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984). This specialist found the evidence insufficient to diagnose either clinical or legal pneumoconiosis. Moreover, Dr. Jarboe's opinion is supported by Dr. Robinette's various progress notes generated

in 2002, wherein this pulmonary physician made no mention of pneumoconiosis or any disease that had arisen from Claimant's occupation as a miner.

Dr. Rasmussen found the evidence insufficient to diagnose medical pneumoconiosis. However, he diagnosed legal pneumoconiosis, because he believed Claimant's coal dust exposure and inhalation contributed to his COPD. He based his finding on Claimant's eleven years of coal mine employment, which he stated was "sufficient to contribute" to his chronic lung disease. However, Claimant only worked for 3.5 years in qualifying coal mine employment. Therefore, I assign less weight to Dr. Rasmussen's opinion on this issue because his diagnosis of legal pneumoconiosis was based on an inaccurate occupational history. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993)(per curiam). Further, I assign less weight to Dr. Rasmussen's opinion because his credentials are not equal to those of Drs. Robinette and Jarboe in the area of pulmonary medicine.

Assigning greater weight to the opinions of Drs. Jarboe, supported by the notable omissions in Dr. Robinson's report, I find this evidence does not establish the existence of pneumoconiosis by medical opinions under § 718.202(a)(4). Weighing the medical evidence along with the x-ray evidence, I also find that this evidence, weighed together, does not establish the existence of pneumoconiosis under Part 718 of the regulations.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment. 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2004). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2004). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2004); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas tests, and medical opinions.

Pulmonary Function Tests

None of the PFTs submitted in support of this claim produced qualifying values; thus, this evidence does not support a finding of total disability under 20 CFR § 718.204(b)(2)(i).

Arterial Blood Gas Studies

The exercise ABG test conducted on May 12, 2005, resulted in qualifying values under the regulations. However, the resting test performed that date and the test performed on January 26, 2006 were not qualifying. I assign greater probative value to the most recent test. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993) (more weight may be accorded to the results of a recent blood gas study over a study that was conducted earlier). Therefore, this evidence cannot support a finding of total disability due to a respiratory impairment under § 718.204(b)(2)(ii).

Medical Opinions

Dr. Rasmussen found that Claimant did not retain the respiratory pulmonary capacity to perform his last regular coal mine work. However, I assign less weight to this opinion because this doctor did not provide a reasoned and documented basis for this opinion. *See Scott Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987).

Dr. Robinette did not offer an opinion about whether Claimant could return to his usual coal mine work. He only noted a "mild" obstructive lung disease and Claimant's various conditions that could be contributing to his pulmonary difficulty. Therefore, this physician's opinion has little probative value surrounding the issue of total disability.

Based on his own pulmonary function test results conducted on January 26, 2006, Dr. Jarboe found that the Claimant retained the functional respiratory capacity to do his last coal mine job or work with similar physical demands. I assign the greatest probative weight to Dr. Jarboe's opinion for the same reasons explained, above. Dr. Jarboe's report does not support a finding of total disability due to a respiratory disease. Weighing the medical opinions, and assigning the greatest probative weight to Dr. Jarboe's opinion, I find that the medical opinion evidence does not establish, by a preponderance of this evidence, total respiratory disability, pursuant to § 718.204(b)(2)(iv).

Weighing the non-qualifying pulmonary function studies and the non-qualifying blood gas values along with the medical opinion evidence, I find that this evidence, considered altogether, does not establish total disability due to a respiratory disease under § 718.204(b)(2).

Causation of Total Disability

As I have found that the evidence does not establish the Claimant has pneumoconiosis or that he is totally disabled, he cannot establish that pneumoconiosis is a substantial contributor to his disability. In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to the miner's disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine

employment. 20 CFR § 718.204(c) (2004); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990); *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3rd Cir. 1989).

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he has pneumoconiosis and that he is totally disabled, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. See Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by the Claimant, N.S., on February 2, 2005, is hereby DENIED.

William S. Colwell

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:BG

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 CFR §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 CFR § 802.207. Once an appeal is filed, all inquiries and correspondences should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 CFR §725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 CFR §725.479(a).